

		FOR OHF USE					

LL1

2001  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2001)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041996

Facility Name: Sunset Manor Nursing Home

Address: 129 South First Avenue Canton 61520  
Number City Zip Code

County: Fulton

Telephone Number: (309) 674-4327 Fax # (309) 674-4354

IDPA ID Number: 370997695001

Date of Initial License for Current Owners: 08/01/1990

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

In the event there are further questions about this report, please contact  
Name: Christine A. Hanover Telephone Number: (312) 634-3400  
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) (Date)

(Type or Print Name)

(Title)

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)

(Print Name and Title)

(Firm Name & Address) Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606

(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE  
ILLINOIS DEPARTMENT OF PUBLIC AID  
201 S. Grand Avenue East  
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Sunset Manor Nursing Home

#    0041996      Report Period Beginning:      01/01/2001      Ending:    12/31/2001

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <u>02/16/01</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)	18	5,742	1
2		Skilled Pediatric (SNF/PED)			2
3	95	Intermediate (ICF)	87	32,123	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	95	TOTALS	105	37,865	7

D. How many bed-hold days during this year were paid by Public Aid?  
385 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)  
None

F. Does the facility maintain a daily midnight census?      Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES    ☒      NO    ☐      Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES    ☐      NO    ☒

I. On what date did you start providing long term care at this location?  
Date started      08/01/1990

J. Was the facility purchased or leased after January 1, 1978?  
YES    ☒      Date    08/01/1990      NO    ☐

K. Was the facility certified for Medicare during the reporting year?  
YES    ☐      NO    ☒      If YES, enter number of beds certified      0      and days of care provided      0

Medicare Intermediary    N/A

IV. ACCOUNTING BASIS

ACCRUAL    ☒      MODIFIED CASH\*    ☐      CASH\*    ☐

Is your fiscal year identical to your tax year?      YES    ☒      NO    ☐

B. Census-For the entire report period.						
	1 Level of Care	2				

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 95.75%

Tax Year: 12/31/01 Fiscal Year: 12/31/01  
\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT



29	(sum of lines 8, 16 & 28)	1,969,658	332,047	628,245	2,929,950		2,929,950	(39,658)	2,890,292		29
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\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7**	8			
30	Depreciation			88,681	88,681		88,681	42,557	131,238			30
31	Amortization of Pre-Op. & Org											31
32	Interest			49,937	49,937		49,937	250,508	300,445			32
33	Real Estate Taxes			12,494	12,494		12,494	(237)	12,257			33
34	Rent-Facility & Grounds			274,347	274,347		274,347	(270,598)	3,749			34
35	Rent-Equipment & Vehicles			1,757	1,757		1,757	2,610	4,367			35
36	Other (specify):*											36
37	TOTAL Ownership			427,216	427,216		427,216	24,840	452,056			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Center:		1,581		1,581		1,581		1,581			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			56,798	56,798		56,798		56,798			42
43	Other (specify):* Nonallowable costs			32,629	32,629		32,629	(32,629)				43
44	TOTAL Special Cost Centers		1,581	89,427	91,008		91,008	(32,629)	58,379			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,969,658	333,628	1,144,888	3,448,174		3,448,174	(47,447)	3,400,727			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

\*\*See schedule of adjustments attached at end of cost report

**SEE ACCOUNTANTS' COMPILATION REPORT**



**VI. ADJUSTMENT DETAIL** A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column '

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals	(2,176)	2		4
5	Telephone, TV & Radio in Resident Room	(5,086)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(32,025)	30		9
10	Interest and Other Investment Income	(23,249)	32		10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(508)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(536)	43		18
19	Entertainment				19
20	Contributions	(4,384)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individual				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotions	(15,885)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employee				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See Attached Schedule 5A</u>	(7,409)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (91,258)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule'	\$		31
32	Donated Goods-Attach Schedule'			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	43,811		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 43,811		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ (47,447)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46

OHF USE ONLY									
48		49		50		51		52	

47	TOTAL (C): (sum of lines 38-46)		\$		47
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SEE ACCOUNTANTS' COMPILATION REPORT

Sunset Manor Nursing Home  
Provider # 0041996  
12/31/2001

**Schedule 5A**

VI. Adjustment Detail  
Non-allowable Expenses - Line 29

Type	Amount	Reference
Offset transportation income	-403	25
Offset miscellaneous income	-489	21
Disallow PAC dues	-76	20
Disallow Chamber of Commerce dues	-370	20
Disallow non-allowable dues	-70	20
Disallow special events	-6230	43
Nonallowable legal fees	229	19
	<u>-7409</u>	

**See Accountants' Compilation Report**

Sunset Manor Nursing Home

Report Period Beginning:

Ending:

ID#

0041996

01/01/2001

12/31/2001

NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1	\$		1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22

23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sunset Manor Nursing Home

# 0041996

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	32	0	0	0	0	0	0	0	0	0	32	1
2	Food Purchase	(2,176)	0	0	0	0	0	0	0	0	0	0	(2,176)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	595	0	0	0	0	0	0	0	0	0	595	5
6	Maintenance	0	729	0	0	0	0	0	0	0	0	0	729	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(2,176)</b>	<b>1,356</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(820)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	6	0	0	0	0	0	0	0	0	0	6	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>6</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>6</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(82,875)	0	0	0	0	0	0	0	0	0	(82,875)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,004	0	0	0	0	0	0	0	0	0	5,004	19
20	Fees, Subscriptions & Promotions	0	464	0	0	0	0	0	0	0	0	0	464	20
21	Clerical & General Office Expense	0	14,389	0	0	0	0	0	0	0	0	0	14,389	21
22	Employee Benefits & Payroll Tax	0	18,506	0	0	0	0	0	0	0	0	0	18,506	22
23	Inservice Training & Education	0	65	0	0	0	0	0	0	0	0	0	65	23
24	Travel and Seminar	0	1,939	0	0	0	0	0	0	0	0	0	1,939	24
25	Other Admin. Staff Transportat	0	2,161	0	0	0	0	0	0	0	0	0	2,161	25
26	Insurance-Prop.Liab.Malpractice	0	2,682	0	0	0	0	0	0	0	0	0	2,682	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>0</b>	<b>(37,665)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(37,665)</b>	<b>28</b>

[illegible]





VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Petersen	100%	See Attached Schedule		See Attached Schedule		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ X YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1	Dietary	\$	Petersen Health Care Companies	0.00%	\$ 32	\$ 32	1
2	V	5	Utilities		Petersen Health Care Companies	0.00%	595	595	2
3	V	6	Maintenance Supplies		Petersen Health Care Companies	0.00%	729	729	3
4	V	12	Social Services		Petersen Health Care Companies	0.00%	6	6	4
5	V	17	Administrative	82,875	Petersen Health Care Companies	0.00%		(82,875)	5
6	V	19	Professional Services		Petersen Health Care Companies	0.00%	5,004	5,004	6
7	V	20	Fees, Subscriptions & Promotions		Petersen Health Care Companies	0.00%	464	464	7
8	V	21	Clerical & General Office Exp.		Petersen Health Care Companies	0.00%	14,389	14,389	8
9	V	22	Employee Benefits		Petersen Health Care Companies	0.00%	18,506	18,506	9
10	V	23	Inservices Training & Education		Petersen Health Care Companies	0.00%	65	65	10
11	V	24	Travel & Seminar		Petersen Health Care Companies	0.00%	1,939	1,939	11
12	V	25	Other Admin. Staff Transport.		Petersen Health Care Companies	0.00%	2,161	2,161	12
13	V	26	Insurance-Prop. Liab. Malpractice		Petersen Health Care Companies	0.00%	2,682	2,682	13
14	Total			\$ 82,875			\$ 46,572	\$ * (36,303)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ X

 YES

☐

 NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	\$	Petersen Health Care Companies	0.00%	\$ 8,848	\$ 8,848	15
16	V	32	Interest		Petersen Health Care Companies	0.00%	1,424	1,424	16
17	V	34	Rent - Facility & Grounds		Petersen Health Care Companies	0.00%	3,749	3,749	17
18	V	35	Rent - Equipment & Vehicles		Petersen Health Care Companies	0.00%	2,610	2,610	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 16,631	\$ * 16,631	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	\$	Petersen Properties	0.00%	\$ 65,734	\$ 65,734	15
16	V	32	Amortization of loan cost		Petersen Properties	0.00%	18,715	18,715	16
17	V	32	Interest expenses		Petersen Properties	0.00%	253,618	253,618	17
18	V	33	Real estate taxes	12,494	Petersen Properties	0.00%	12,257	(237)	18
19	V	34	Rent	274,347	Petersen Properties	0.00%		(274,347)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 286,841			\$ 350,324	\$ * 63,483	39

**Sunset Manor Nursing Home**  
**Provider # 0041996**  
**12/31/2001**

**VII Related Parties-Page 6**

**Related Nursing Home**

Countryview Terrace  
Bement Health Care Center  
Sunset Manor Nursing Home  
Kewanee Care Home  
Robings Manor Nursing Home  
Eastview Terrace  
Havana Health Care Center  
Prairie City Health Care Center  
Arcola Health Care Center

**City**

Louisville, IL  
Bement, IL  
Canton, IL  
Kewanee, IL  
Brighton, IL  
Sullivan, IL  
Havana, IL  
Prairie City, IL  
Arcola, IL

**Out of State Nursing Home**

Friendly Village  
Horizons Unlimited  
Taylor Park  
Passport  
Meadow Lawn Nursing Center  
Cumberland Heights-Tomahawk  
Maple Park  
Opportunities Unlimited (Workshop setup, no beds)

Rhineland, WI  
Rhineland, WI  
Rhineland, WI  
Rhineland, WI  
Davenport, IA  
Tomahawk, WI  
Rhineland, WI

**Other Related Business Entities**

Petersen Health Care Companies  
Petersen Property

Peoria, IL Management/ Bookkeeping  
Canton, IL Building-Sunset Manor

**See Accountants' Compilation Report**

Facility Name & ID Number Sunset Manor Nursing Home # 0041996 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Petersen	President	Administrative	100.00	474,150	8	20.00	Salary	\$ 91,851	L17, C1	1
2	Mark Petersen	Secretary	Administrative	0.00	205,703	8	20.00	Salary	39,848	L17, C1	2
3	Todd Petersen	Administrative	Administrative	0.00	59,759	8	20.00	Salary	11,576	L21, C1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 143,275		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

**SEE ACCOUNTANTS' COMPILATION REPORT**

Sunset Manor Nursing Home  
Provider # 0041996  
12/31/2001

Schedule 7A

VII. Related Parties (continued)  
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.  
    Compensation Received From Other Nursing Homes

Name	Bement Health Care	Country View Terrace	Eastview Terrace	Arcola Health Care	Meadow Lawn Nursing	Robings Manor	Kewanee Care Center	Havana Care Center	Prairie City	Total	Sunset Manor	Grand Total
James Petersen	53,064	14,795	52,568	88,261	58,818	60,034	68,695	59,421	18,494	474,150	91,851	566,001
Mark Petersen	23,021	6,419	22,806	38,291	25,517	26,045	29,802	25,779	8,023	205,703	39,848	245,551
Todd Petersen	6,688	1,865	6,625	11,124	7,413	7,566	8,658	7,489	2,331	59,759	11,576	71,335
Total Compensation Received From Other Nursing Homes	82,773	23,079	81,999	137,676	91,748	93,645	107,155	92,689	28,848	739,612	143,275	882,887

See Accountants' Compilation Report



Facility Name & ID Number     Sunset Manor Nursing Home#     0041996

Report Period Beginning:

01/01/2001Ending:     2/31/2001

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)     YES ☒     NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization

Petersen Health Care Companies

Street Address

7218 North Villa Lake

City / State / Zip Code

Peoria, IL 61614

Phone Number

( 309) 691-8113

Fax Number

( 309) 691-8622

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8  Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	223,416	8	\$ 200	\$ 0	36,256	\$ 32	1
2	5	Utilities	Patient Days	223,416	8	3,666	0	36,256	595	2
3	6	Maintenance Supplies	Patient Days	223,416	8	4,490	0	36,256	729	3
4	12	Social Services	Patient Days	223,416	8	40	0	36,256	6	4
5	19	Professional Services	Patient Days	223,416	8	30,834	0	36,256	5,004	5
6	20	Fees, Subscriptions & Promotions	Patient Days	223,416	8	2,859	0	36,256	464	6
7	21	Clerical & General Office Exp.	Patient Days	223,416	8	88,667	0	36,256	14,389	7
8	22	Employee Benefits	Patient Days	223,416	8	114,040	0	36,256	18,506	8
9	23	Inservices Training & Education	Patient Days	223,416	8	402	0	36,256	65	9
10	24	Travel & Seminar	Patient Days	223,416	8	11,946	0	36,256	1,939	10
11	25	Other Admin. Staff Transport.	Patient Days	223,416	8	13,319	0	36,256	2,161	11
12	26	Insurance-Prop. Liab. Malpractice	Patient Days	223,416	8	16,524	0	36,256	2,682	12
13	30	Depreciation	Patient Days	223,416	8	54,520	0	36,256	8,848	13
14	32	Interest	Patient Days	223,416	8	8,774	0	36,256	1,424	14
15	34	Rent - Facility & Grounds	Patient Days	223,416	8	23,100	0	36,256	3,749	15
16	35	Rent - Equipment & Vehicles	Patient Days	223,416	8	16,083	0	36,256	2,610	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 389,464	\$		\$ 63,203	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	First Bank of America		X	Mortgage	\$22,862.00	07/24/00	\$ 2,350,000	\$ 2,329,768	07/24/05	0.1150	\$ 253,618	1	
2	First Bank of Canton		X	Vehicle Loan	\$1,007.00	11/11/97	51,500	3,964	11/10/02	0.0850	808	2	
3	Bank of Farmington		X	Vehicle Loan	\$1,152.00	9/21/01	55,280	51,825	01/2006	0.0725	464	3	
4												4	
5												5	
	Working Capital												
6	First Bank of America		X	Line of Credit	Varies	02/02/95	1,288,373	711,384	08/01/02	0.0950	48,665	6	
7	Installment Notes		X	Working Capital	None	Various	11,000	11,000	None	None		7	
8												8	
9	TOTAL Facility Related				\$25,021.00		\$ 3,756,153	\$ 3,107,941			\$ 303,555	9	
	B. Non-Facility Related*												
10								Home office allocation			1,424	10	
11								Interest income offset			(23,249)	11	
12								Amortization of loan cost			18,715	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (3,110)	14	
15	TOTALS (line 9+line14)						\$ 3,756,153	\$ 3,107,941			\$ 300,445	15	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

**SEE ACCOUNTANTS' COMPILATION REPORT**



application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

## 2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. 09-08-27-438-012	E1, 4 70 E1,4 S42 1, 2	\$ 166.00	\$ 166.00



X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

27,554

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

Two

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's groun (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc. List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

N/A

2. Number of Years Over Which it is Being Amortized:

N/A

3. Current Period Amortization:

N/A

4. Dates Incurred:

N/A

Nature of Costs:

N/A

(Attach a complete schedule detailing the total amount of organization and pre-operating costs

XI. OWNERSHIP COSTS:

		1	2	3	4	
		Use	Square Feet	Year Acquired	Cost	
A. Land.	1	Facility	Allocation-		\$	1
	2		Petersen Prop.	1990	23,000	2
	3	TOTALS			\$ 23,000	3

SEE ACCOUNTANTS' COMPILATION REPORT



**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	95		1990	1972	\$ 1,046,508	\$	30	\$ 34,884	\$ 34,884	\$ 398,308	4
5	10*			2001	1,333,951		20	27,078	27,078	27,078	5
6				2001	413,768	8,958	20	10,344	1,386	10,344	6
7											7
8											8
	Improvement Type**										
9	Petersen Properties Building Partnership			1990	6,417		15	428	428	4,815	9
10	Petersen Properties Building Partnership			1991	10,127		15	675	675	7,144	10
11	Petersen Properties Building Partnership			1993	4,719		15	315	315	2,546	11
12	Petersen Properties Building Partnership			1994	1,780		15	119	119	912	12
13	Petersen Properties Building Partnership			1995	13,199		20	660	660	4,446	13
14											14
15	Field Audit			1990	1,102		15	73	73	843	15
16	Drapes			1995	8,206	723	20	410	(313)	2,597	16
17	Remodeling			1996	14,630	375	20	733	358	3,783	17
18	Awning			1996	1,105	99	20	55	(44)	280	18
19	Landscaping			1996	4,036	280	20	202	(78)	1,145	19
20	Back Taxes on Land			1996	531		20	26	26	104	20
21	Tiling			1997	500		20	25	25	100	21
22	Doors			1997	5,250	135	20	263	128	1,315	22
23	Tiling			1997	8,228	211	20	411	200	2,021	23
24	Gutters			1997	2,759	71	20	138	67	656	24
25	Landscaping			1997	1,886	143	20	94	(49)	447	25
26	Door Closer			1997	1,688	43	20	84	41	364	26
27	Concrete Slab			1997	1,440	37	20	72	35	336	27
28	Painting			1997	1,207	31	20	60	29	285	28
29	Furnace			1997	2,389	61	20	119	58	496	29
30	Awning			1997	4,077		20	204	204	918	30
31	Telephone System			1997	1,189	167	20	59	(108)	251	31
32	Roof/Windows			1998	36,145	927	20	1,807	880	6,325	32
33	Drapery			1998	1,402	36	20	70	34	245	33
34	Expansion Design			1998	3,639		20	182	182	637	34
35	Flooring/Cove Base			1998	619	16	20	31	15	108	35
36	* Petersen Properties Building Partnership										36

\*Total beds on this schedule must agree with page 2

\*\*Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Awnings	1999	\$ 353	\$ 86	20	\$ 18	\$ (68)	\$ 45	37
38	Roof (Balance)	1999	1,000	26	20	50	24	125	38
39	Drapes	2000	1,966	40	20	98	58	147	39
40	Remove Trees	2000	1,072	19	20	54	35	81	40
41	Expansion	2000	1,945	31	20	98	67	147	41
42	Wood	2000	1,072	17	20	54	37	81	42
43	Land Work	2000	2,510	40	20	126	86	189	43
44	Flooring	2000	1,168	1	20	58	57	87	44
45	Shades	2001	1,788	36	20	45	9	45	45
46	Painting	2001	2,228	36	20	56	20	56	46
47	Carpet	2001	4,841	78	20	121	43	121	47
48	Carpet	2001	8,000	111	20	200	89	200	48
49	Painting	2001	345	5	20	9	4	9	49
50	Fire System	2001	42,286	226	20	1,057	831	1,057	50
51	Carpet	2001	2,155	7	20	54	47	54	51
52	Kitchen Remodeling	2001	43,315	217	20	1,083	866	1,083	52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,048,541	\$ 13,289		\$ 82,801	\$ 69,512	\$ 482,375	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$203,054	\$16,905	\$20,307	\$3,402	10	\$66,421	71
72	Current Year Purchases	116,880	17,074	11,688	(5,386)	10	11,688	72
73	Fully Depreciated Assets	165,723					165,723	73
74								74
75	TOTALS	\$485,657	\$33,979	\$31,995	\$(1,984)		\$243,832	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1990 Dodge Intrepid	1994	\$32,448	\$1,675	\$	\$(1,675)	4	\$32,448	76
77	Facility	1997 Ford E350 Van	1997	41,836	7,631	10,459	2,828	4	41,836	77
78	Facility	2001 Dodge Caravan	2001	47,863	9,573	5,983	(3,590)	4	5,983	78
79										79
80	TOTALS			\$122,147	\$18,879	\$16,442	\$(2,437)		\$80,267	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$3,679,34581
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$66,14782
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$131,23883
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$65,09184
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$806,47485

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Petersen Properties
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions. ☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5		Home office allocation			3,749			5
6								6
7	TOTAL				\$ 3,749			7

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized  
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: \$ 4,367 Description: Copy Machine-\$335, ;Dishwasher-\$1422 ;Home Office Allocation-\$2610  
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning  
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	\$
13.	/2003	\$
14.	/2004	\$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

YES

X

NO

It is the policy of this facility to only hire certified nurses aides  
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides
- SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$			1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L 10a C 1	693 hrs	19,701				693	19,701	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				1,581		1,581	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$ 19,701		\$	\$ 1,581	693	\$ 21,282	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable Patients (less allowance <u>None</u> )	381,014	381,014	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,443	9,443	6
7	Other Prepaid Expenses	9,606	9,606	7
8	Accounts Receivable (owners or related parties			8
9	Other(specify): <u>Due from related party</u>	418,469	418,469	9
10	<b>TOTAL Current Assets</b> <b>(sum of lines 1 thru 9)</b>	\$ 818,532	\$ 818,532	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	70,630	23,000	13
14	Buildings, at Historical Cost	617,018	3,048,541	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	621,276	607,804	16
17	Accumulated Depreciation (book methods	(396,160)	(806,474)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) <u>Unimproved Land</u>		70,630	22
23	Other(specify): _____			23
24	<b>TOTAL Long-Term Assets</b> <b>(sum of lines 11 thru 23)</b>	\$ 912,764	\$ 2,943,501	24

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 227,761	\$ 227,761	26
27	Officer's Accounts Payable	28,000	28,000	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	11,000	11,000	29
30	Accrued Salaries Payable	84,742	84,742	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		12,660	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See attached Schedule 17A</u>	144,086	166,622	36
37	<u>Due to Related Party</u>	100,000	100,000	37
38	<b>TOTAL Current Liabilities</b> <b>(sum of lines 26 thru 37)</b>	\$ 595,589	\$ 630,785	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	767,173	767,173	39
40	Mortgage Payable		2,329,768	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	_____			43
44	_____			44
45	<b>TOTAL Long-Term Liabilities</b> <b>(sum of lines 39 thru 44)</b>	\$ 767,173	\$ 3,096,941	45
46	<b>TOTAL LIABILITIES</b> <b>(sum of lines 38 and 45)</b>	\$ 1,362,762	\$ 3,727,726	46



25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,731,296	\$ 3,762,033	25

47	TOTAL EQUITY(page 18, line 24)	\$ 368,534	\$ 34,307	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,731,296	\$ 3,762,033	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

Sunset Manor Nursing Home  
Provider # 0041996  
12/31/2001

**Schedule 17A**

XV. Balance Sheet

Line 36: Other Current Liabilities

	Operating	After Consolidation
Accrued insurance - w/s	(5,742)	(5,742)
Accrued interest	(3,326)	(25,862)
Accrued insurance - General	(4,353)	(4,353)
Accrued sales tax	(508)	(508)
Cash in Bank - Gen	(145,195)	(145,195)
Wage garnishment	14,088	14,088
Imprest - bread fund	150	150
Imprest fund	800	800
Total	(144,086)	(166,622)

**See Accountants' Compilation Report**

## XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 708,638	1
2	Restatements (describe):		2
3			3
4	Prior period adjustment	(6,457)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 702,181	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(239,647)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owner:	(94,000)	13
14	Donated Property, Plant, and Equipmen		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (333,647)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 368,534	24 *

Operating entity only

\* This must agree with page 17, line 47.

**SEE ACCOUNTANTS' COMPILATION REPORT**

## STATE OF ILLINOIS

Page 19

Facility Name &amp; ID Number Sunset Manor Nursing Home

# 0041996

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 3,174,541	1
2	Discounts and Allowances for all Levels	3,224	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,177,765	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,160	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 5,160	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursement		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,176	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	(715)	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,461	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income**	23,249	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 23,249	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	757,338	31
32	Health Care	1,357,923	32
33	General Administration	814,689	33
	<b>B. Capital Expense</b>		
34	Ownership	427,216	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	34,210	35
36	Provider Participation Fee	56,798	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,448,174	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(239,647)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (239,647)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.  
Entity is a cash basis taxpayer.

28	Transportation	403	28
28a	Miscellaneous	489	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 892	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,208,527	30

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number      Sunset Manor Nursing Home#   0041996Report Period Beginning:      01/01/2001Ending:      12/31/2001

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,907	2,027	\$ 47,750	\$ 23.56	1
2	Assistant Director of Nursing	1,820	1,820	36,068	19.82	2
3	Registered Nurses	8,902	8,974	180,156	20.08	3
4	Licensed Practical Nurses	17,622	18,848	270,163	14.33	4
5	Nurse Aides & Orderlies	65,327	68,590	628,739	9.17	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	693	693	19,701	28.43	7
8	Rehab/Therapy Aides	1,127	1,127	17,464	15.50	8
9	Activity Director	1,948	1,974	15,303	7.75	9
10	Activity Assistants	2,984	3,000	20,029	6.68	10
11	Social Service Workers	2,080	2,080	23,160	11.13	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	20,280	9.75	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,511	17,319	123,068	7.11	15
16	Dishwashers					16
17	Maintenance Workers	3,973	3,973	46,409	11.68	17
18	Housekeepers	17,565	18,404	135,363	7.36	18
19	Laundry	8,167	8,514	55,542	6.52	19
20	Administrator	2,080	2,080	59,252	28.49	20
21	Assistant Administrator					21
22	Other Administrative	690	690	131,699	190.87	22
23	Office Manager					23
24	Clerical	7,408	7,408	89,984	12.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,005	1,005	7,994	7.95	31
32	Other Health Care: <u>Care Plan Coordinator</u>	2,253	2,253	41,534	18.43	32
33	Other(specify) _____					33

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	42	\$ 1,660	L1, C3	35
36	Medical Director	Monthly	960	L9, C3	36
37	Medical Records Consultant	7	197	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	275	L10, C3	39
40	Physical Therapy Consultant	9	428	L10A, C3	40
41	Occupational Therapy Consultant	Monthly	1,181	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	80	2,385	L10A, C3	43
44	Activity Consultant	22	640	L11, C3	44
45	Social Service Consultant	23	640	L12, C3	45
46	Other(specify) _____				46
47	_____				47
48	_____				48
49	TOTAL (lines 35 - 48)	183	\$ 8,366		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

34	TOTAL (lines 1 - 33)	166,142	172,859	\$ 1,969,658 *	\$ 11.39	34	SEE ACCOUNTANTS' COMPILATION REPORT
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\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.



Facility Name & ID Number		Sunset Manor Nursing Home		STATE OF ILLINOIS		Report Period Beginning:		01/01/2001		Page 21		Ending:		12/31/2001	
XIX. SUPPORT SCHEDULES															
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions							
Name		Function	Ownership %	Amount		Description		Amount		Description		Amount			
Cindy White		Administrator	0%	\$ 59,252		Workers' Compensation Insurance		\$ 47,092		IDPH License Fee		\$			
						Unemployment Compensation Insurance		23,597		Advertising: Employee Recruitment		1,975			
						FICA Taxes		130,579		Health Care Worker Background Check					
James Petersen		Administrator	100%	91,851		Employee Health Insurance		58,893		(Indicate # of checks performed 32 )		384			
Mark Petersen		Administrator	0%	39,848		Employee Meals				Illinois Health Care Assn. Dues		6,382			
						Illinois Municipal Retirement Fund (IMRF)*				Miscellaneous dues		1,190			
						Retirement plan - 401(k)		3,700		Miscellaneous licenses & fees		979			
						Employee life insurance		925		Miscellaneous subscriptions					
						Employee morale		10,236							
TOTAL (agree to Schedule V, line 17, col. 1)															
(List each licensed administrator separately.)				\$ 190,951											
B. Administrative - Other															
Description				Amount											
Management fees (eliminated in column 7)				\$ 82,875		Home office allocation		18,506							
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 82,875		TOTAL (agree to Schedule V, line 22, col.8)		\$ 293,528		TOTAL (agree to Sch. V, line 20, col. 8)		\$ 11,374			
(Attach a copy of any management service agreement)						E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**					
Vendor/Payee		Type		Amount		Description		Line #	Amount		Description		Amount		
				\$					\$		Out-of-State Travel		\$		
						N/A									
See Schedule 21C				49,011							In-State Travel		3,836		
											See attached schedule				
											Seminar Expense		1,048		
											See attached schedule				
											Home office allocation		1,939		
											Entertainment Expense		( )		
TOTAL (agree to Schedule V, line 19, column 3)						TOTAL		\$		(agree to Sch. V, line 24, col. 8)					
(If total legal fees exceed \$2500 attach copy of invoices.)				\$ 49,011						TOTAL		\$ 6,823			

**\* Attach copy of IMRF notifications**  
**SEE ACCOUNTANTS' COMPILATION REPORT**

**\*\*See instructions.**

Sunset Manor Nursing Home  
Provider # 0041996  
12/31/2001

**Schedule 21C**

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor/ Payee	Type	Amount
Bush & Snyder	Legal	805
Claudon, Barnhart, etal.	Legal	83
Duane, Morris & Heckscher	Legal	27,836
OTV	Legal	(500)
Ginoli & Co.	Accounting	4,589
Altschuler, Melvoin &Glasser LLP	Accounting	4,633
American Express Tax & Bus. Services	Accounting	630
Cindy Howel	Accounting	41
ADP	Payroll	7,994
United Security Commission	Computer consultation	440
AHCA	Computer consultation	425
Mid America Programming	Computer consultation	1,500
America Online	Computer consultation	125
Discover Card	Computer consultation	60
Rudy Hadsell	Computer consultation	<u>350</u>

TOTAL (agree to Schedule V, line 19, column 3)	<u>49,011</u>
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Disallowed Legal fees -Duane Morris & Heckscher	(271)
Disallowed Legal fees -OTV	500

Home office allocation	
Computer Services	1,540
Accounting - AM&G	29
Accounting - Ginoli	2,988
Accounting - Brighton	118
Legal - Bush, Snyder & Assoc.	329

TOTAL (agree to Schedule V, line 19, column 8)	<u>54,244</u>
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**See Accountants' Compilation Report**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4		N/A											
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunset Manor Nursing Home# 0041996Report Period Beginning: 01/01/2001Ending: 12/31/2001**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union No
- (2) Are there any dues to nursing home associations included on the cost report Yes  
If YES, give association name and amount Illinois Health Care Assn. - \$6,382
- (3) Did the nursing home make political contributions or payments to a political organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. \$ 2,442 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 56,798  
This amount is to be recorded on line 42 of Schedule V

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,176
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation  
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such program during this reporting period. \$ 403  
c. What percent of all travel expense relates to transportation of nurses and patients? 10%  
d. Have vehicle usage logs been maintained? Adequate records are being maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? N/A  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out

(12) Are there any salary costs which have been allocated to more than one line on Schedule  
for an individual employee? No If YES, attach an explanation of the allocation

SEE ACCOUNTANTS' COMPILATION REPORT

out of Schedule V? N/A

(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of service  
performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fee.

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustmen	Adjusted Total
1. Dietary	143,348	20,356	1,660	165,364	0	165,364	32	165,396
2. Food Pr	0	167,989	0	167,989	0	167,989	-2,176	165,813
3. Housek	135,363	12,017	0	147,380	0	147,380	0	147,380
4. Laundry	55,542	17,280	0	72,822	0	72,822	0	72,822
5. Heat an	0	0	76,590	76,590	0	76,590	595	77,185
6. Mainten	46,409	59,226	21,558	127,193	0	127,193	729	127,922
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	380,662	276,868	99,808	757,338	0	757,338	-820	756,518
9. Medical	0	0	960	960	0	960	0	960
10. Nursin	1,229,868	40,267	1,019	1,271,154	0	1,271,154	0	1,271,154
10a. Thera	19,701	0	3,994	23,695	0	23,695	0	23,695
11. Activiti	35,332	987	640	36,959	0	36,959	0	36,959
12. Social	23,160	1,355	640	25,155	0	25,155	6	25,161
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total H	1,308,061	42,609	7,253	1,357,923	0	1,357,923	6	1,357,929
17. Admin	190,951	0	82,875	273,826	0	273,826	-82,875	190,951
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	49,011	49,011	0	49,011	5,233	54,244
20. Fees,	0	0	11,426	11,426	0	11,426	-52	11,374
21. Clerica	89,984	12,570	30,759	133,313	0	133,313	13,900	147,213
22. Emplo	0	0	275,022	275,022	0	275,022	18,506	293,528
23. Inservi	0	0	4,101	4,101	0	4,101	65	4,166
24. Travel	0	0	4,884	4,884	0	4,884	1,939	6,823



25. Other	0	0	9,392	9,392	0	9,392	1,758	11,150
26. Insura	0	0	53,714	53,714	0	53,714	2,682	56,396
27. Other	0	0	0	0	0	0	0	0
28. Total C	280,935	12,570	521,184	814,689	0	814,689	-38,844	775,845
29. Total C	1,969,658	332,047	628,245	2,929,950	0	2,929,950	-39,658	2,890,292
30. Deprec	0	0	88,681	88,681	0	88,681	42,557	131,238
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	49,937	49,937	0	49,937	250,508	300,445
33. Real E	0	0	12,494	12,494	0	12,494	-237	12,257
34. Rent -	0	0	274,347	274,347	0	274,347	-270,598	3,749
35. Rent -	0	0	1,757	1,757	0	1,757	2,610	4,367
36. Other	0	0	0	0	0	0	0	0
37. Total C	0	0	427,216	427,216	0	427,216	24,840	452,056
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	1,581	0	1,581	0	1,581	0	1,581
40. Barber	0	0	0	0	0	0	0	0
41. Coffee	0	0	0	0	0	0	0	0
42	0	0	56,798	56,798	0	56,798	0	56,798
43. Other	0	0	32,629	32,629	0	32,629	-32,629	0
44. Total S	0	1,581	89,427	91,008	0	91,008	-32,629	58,379
45. Grand	1,969,658	333,628	1,144,888	3,448,174	0	3,448,174	-47,447	3,400,727

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	0	0
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	381,014	381,014
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	9,443	9,443
7. Other Prepaid Expenses	9,606	9,606
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	418,469	418,469
10. Total current assets	818,532	818,532
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	70,630	23,000
14. Buildings, at Historical Cost	617,018	3,048,541
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	621,276	607,804
17. Accumulated Depreciation (book methods)	-396,160	-806,474
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	70,630
23. other (specify):	0	0
24. Total Long-Term Assets	912,764	2,943,501
25. Total Assets	1,731,296	3,762,033
CURRENT LIABILITIES		

26. Accounts Payable	227,761	227,761
27. Officer's Accounts Payable	28,000	28,000
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	11,000	11,000
30. Accrued Salaries Payable	84,742	84,742
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	12,660
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	144,086	166,622
37. Other Current Liabilities (specify):	100,000	100,000
38. Total Current Liabilities	595,589	630,785
LONG TERM LIABILITES		
39.Long-Term Notes Payable	767,173	767,173
40.Mortgage Payable	0	2,329,768
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	767,173	3,096,941
46.Total Liabilities	1,362,762	3,727,726
47.Total Equity	368,534	34,307
48.Total Liabilities and Equity	1,731,296	3,762,033

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	3,174,541
2. Discounts and Allowances for all Levels	3,224
Subtotal - Inpatient Care	3,177,765
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	5,160
7. Oxygen	0
Subtotal - Ancillary Revenue	5,160
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	2,176
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	0
22. Laundry	-715
Subtotal - Other Operating Revenue	1,461
24. Contributions	0

25. Interest and Other Investments Income	23,249
Subtotal - Non-Operating Revenue	23,249
27. Other Revenue (specify):	892
28. Other Revenue (specify):	0
Subtotal - Other Revenue	892
30. Total Revenue	3,208,527
31. General Services	757,338
32. Health Care	1,357,923
33. General Administration	814,689
34. Ownership	427,216
35. Special Cost Centers	34,210
35. Provider Participation Fee	56,798
37. Other	0
40. Total Expenses	3,448,174
41. Income Before Income Taxes	-239,647
42. Income Taxes	0
43. Net Income or Loss for the Year	-239,647

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10 Attachment of Real Estate Bill and fill out form

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12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached

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19 The bottom right side of page under \*\*, you must write in any comments

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RECONCILIATION REPORT

Sunset Manor Nursing I

04:20 PM

11/07/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CELL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-47,447	equal to	-47,447	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	300,445	equal to	300,445	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	12,257	equal to	12,257	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	131,238	equal to	131,238	0	FAILED	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	3,749	equal to	3,749	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	4,367	equal to	4,367	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	19,701	equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	23,695	equal to	23,695	0	O.K.	Pg16 Z12+Z14..Z16 & Pg 20 X17..X20	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	1,581	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	757,338	equal to	757,338	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,357,923	equal to	1,357,923	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	814,689	equal to	814,689	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	427,216	equal to	427,216	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	34,210	equal to	34,210	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	56,798	equal to	56,798	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,170,870	equal to	1,229,868	-58,998	FAILED	Pg20 K11..K15+K35+K36+K38..K44	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	19,701	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	35,332	equal to	35,332	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	23,160	equal to	23,160	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	143,348	equal to	143,348	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	46,409	equal to	46,409	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	135,363	equal to	135,363	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	55,542	equal to	55,542	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	190,951	equal to	190,951	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	89,984	equal to	89,984	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,969,658	equal to	1,969,658	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	1,660	< or = to	1,660	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	960	< or = to	960	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	472	< or = to	1,019	-547	O.K.	Pg20 X14..X16+X37..X39	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	640	< or = to	640	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3

Social Service Consultant	640	< or = to	640	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	190,951	equal to	190,951	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	82,875	equal to	82,875	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	49,011	equal to	49,011	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	293,528	equal to	293,528	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	11,374	equal to	11,374	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	6,823	equal to	6,823	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	56,798	equal to	56,798	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	N/A	< or = to	18,506	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	N/A	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	0	equal to	146	-146	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	43,811	equal to	43,811	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balance	3,107,941	equal to	3,107,941	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	12,660	equal to	12,660	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	23,000	equal to	23,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	3,048,541	equal to	3,048,541	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	607,804	equal to	607,804	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	806,474	equal to	806,474	0	FAILED	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	368,534	equal to	368,534	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-239,647	equal to	-239,647	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S31	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,731,296	equal to	1,731,296	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1